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ABSTRACT

The paper examines communication between physically impaired and physically nonimpaired people. The paper begins with a definition of key terms (stigmatized and nonstigmatized are used to denote physically impaired and physically-nonimpaired people). It continues with a brief review of the literature in which the inattention to ways of humanizing communication between stigmatized and nonstigmatized persons is pointed out. The impact of body origins on self image is considered, and the need to acknowledge that unresolved feelings of mutual distrust and patronizing responses exist is emphasized. It is concluded that more work needs to be done on preparing both stigmatized and nonstigmatized persons for the emotional aspects of integration, and that nonstigmatized people should begin to resolve their emotional conflicts about physically impaired people. (CL)

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The Dropping of the Caps: A Personalized Approach to Depathologizing Communication Between Physically-Impaired and Physically-Nonimpaired Interactants

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Before addressing the theme of integration into communities and greater independence for physically-impaired people, we need to first take a look at a topic that has been extensively researched over the past twenty years, but one that is infrequently mentioned in forums such as this. It is the topic of communication between physically-impaired and physically-nonimpaired people. Research investigations have substantiated that the dynamics of a typical interaction between the two types of people have been mainly a reactive encounter--one based largely on fears, innocent curiosities, ignorance, rejection, good and sometimes not-so-good intentions, and a host of other feelings that remain unresolved before, during and after the communication event--rather than a cooperative one. We bring this emotional "baggage" into the communication arena, never effectively confronting our anxieties about the interaction, often avoiding the contact, and thereby widening the communicative gap that exists between stigmatized and nonstigmatized people.

My paper will (I) define terminologies; (II) introduce a concept Goffman (1963) has labelled as the "pathology of interaction," a phenomenon of emotional arousal in interactions between physically-impaired and physically-nonimpaired communicators. (III) It will discuss the impact this type of interaction has on both types of interactants; and (IV) it will provide

strategies for "unlearning" behaviors and attitudes that make a mockery of integration and independence for physically-impaired people.

I

This paper defines four key terms: "stigmatized" and "nonstigmatized" will be used respectively to denote physically-impaired and physically-nonimpaired people. The term "handicapped," which is of English derivation meaning "cap in hand," connoting beggars, will not be used. The term "disabled" also will not be used because the descriptor conveys negative connotations and reflects "normal" people's reality rather than my own. A "stigma" will be defined as any discrediting physical condition which does not fit the perceiver's stereotype of what constitutes "normalcy." The "stigma" is therefore a property of the perceiver and not reflective of the person who bears a physical impairment. And a "normal" will hereafter, for purposes of this paper, be considered any physically-nonimpaired perceiver who discriminates against and discredits physically-impaired individuals. Excluded from this definition are perceivers who possess the stigma and persons for whom the physical trait is not a stigma (e.g., intimates and friends of physically-impaired people).

II

According to research conducted by Berger and Calabrese (1975), Wright (1960), and Richardson (1970), physically-stigmatized persons are avoided, judged to be both inferior and not well adjusted, and are unlikely to be selected as friends or colleagues by physically-nonimpaired people. Reactions of this sort toward stigmatized people are "learned" behaviors that do not reflect any inherent feature of the attribute. Reactions of this sort ... need to be and can be "unlearned." Silberberg and Silberberg (1967), in their research investigation, traced the development of perceptions of orthopedic impairments, using 230 physically-nonimpaired children between the ages of 2 and 6. The children responded to a drawing of a child of his own sex wearing bilateral leg braces and to an identical child without leg braces. A battery of standard questions were also asked to tap interpersonal acceptance and understanding of limitations imposed by the physical impairment. The results indicated that the group of five year old children rejected the drawing of the physically impaired child more frequently than that of the non physically-impaired child on the question, "Would you play with him?" Conversely, prior to age four, the children's responses to both drawings were not significantly different. Four years of age was found to be the time at which perceptions of the limitations imposed by the orthopedic impairment first appeared with consistency. The researchers did not describe the nature of these early perceptions in the children, nor did they include

physically-impaired children in their study; nevertheless, the investigation does provide direction for parents and educators to assist pre-school aged children in maintaining and developing positive attitudes about themselves and individuals with physical stigmas. Ray (1948) described that during interaction, normals express viewpoints that are less representative of their own beliefs but are consistent with their stereotypes of what the stigmatized person would like to hear. Numerous other studies, conducted since that time, substantiate the findings that negative behaviors such as these briefly mentioned have to be "unlearned" in order for integration to become a reality. Instead, emphasis is placed on preparing physically-impaired people to "rise to the occasion." Siller, Ferguson, Chipman, and Vann (1967) report in their study that the major responsibility for reducing the strain in social interactions between stigmatized and nonstigmatized interactants lies with the stigmatized communicator. Thus, interaction training is recommended for the physically impaired. To the best of my knowledge, no one has articulated the fact that normals have a shared responsibility with the stigmatized to resolve emotional conflicts that make this type of communication event dysfunctional for the interactants. Very little attention or assistance, has been provided for normals, to aid them in more effectively coping with their negative perceptions of physical impairments and emotional stress. Likewise, the impact that this "pathological interaction" has had on the stigmatized has also been underscored. Rehabilitation programs have been designed to

aid the stigmatized--to "normalize" us into society without regard to developing programs to "humanize" communication between stigmatized and nonstigmatized interactants. The irony is this: We--the stigmatized have become the scapegoats for normals. They, unable to accept responsibility for emotional reactions to physical stigmas, develop rehabilitation programs for the stigmatized without addressing "the problem": their and our emotional conflicts. The problem is one of attitude, not of physical impairment.

III

There is ample evidence which suggests that the self-image evolves out of body origins (e.g., Schilder, 1935) and that throughout life, body-and self-images are intertwined. This being the case, it would follow that physically-stigmatized people are more likely to experience self-rejection due to a personalized relationship with the physical impairment itself and the negative feedback from normals; this stress-provoking situation is further aggravated by societal prejudices, double messages and customs imposed upon the stigmatized. Investigations have revealed that normals' perceptions of the stigmatized adversely affects the self-concepts of stigmatized persons to the extent that we experience self-hate and self-depreciation (Siller et al., 1967); and in lieu of restricted and distorted

interactions, physically-stigmatized people have formed inaccurate, and often negative impressions of nonstigmatized interactants. Likewise, normals react inappropriately to these distortions that they find equally unsettling.

IV

The vicious cycle of negative evaluations, patronizing responses and mutual distrust can be combated by first acknowledging that these unresolved feelings exist. We have for too long been denying this emotional baggage and have created a situation of "mock-integration" and "tokenism," often at the expense of the stigmatized's self-esteem and the nonstigmatized's integrity.

Studies have demonstrated that some physically-nonimpaired people were able to reduce their anxieties about stigmas by gathering information and making inquiries about the impairment. However, more research data has yet to be compiled to substantiate this conclusion. Exposure to the literature that addresses the etiologies of physical impairments may be helpful to grasp a basic understanding of the stigma and facilitate communication between the stigmatized and nonstigmatized interactants. The need to establish support groups, ongoing workshops and counseling sessions that will address the impact of stigmas on interactants cannot be emphasized enough. Training programs and networks need to be established that will remedy this interactional malady. Stigmatized and nonstigmatized people have to be

prepared emotionally for integration. I have not seen enough work in this area. Instead, I see people attending to the letter of the law--more often with reluctance than with sensitivity. Laws are no substitute for the acceptance of people if the reasons for the isolation are not also addressed. The burden of living with normals' reactions for being physically impaired has rested too long on the shoulders of the stigmatized. It is time that normals move toward the resolution of their emotional conflicts, as well as, for the stigmatized to continue efforts in the direction of self- and group-examination in order to gain a sense of self-acceptance and trust. We must provide programs to support efforts in these directions so that the caps can be dropped once and for all.

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